CHECK LIST FOR
ASSISTED LIVING PLAN PREPARATION/CONTENTS

USE OF THIS FORM IS OPTIONAL – OTHER FORMS MAY BE USED THAT MEET REGULATORY REQUIREMENTS

Resident's Name (Printed)	Name of Assisted Living Home
Resident's Social Security Number	Date of Admission
Resident's Date of Birth	Date of Completion of this form

CARE COORDINATOR/CASE MANAGER/PROGRAM SPECIALIST

yes no

___ ___ Does the resident/applicant have a Care Coordinator/Case, Manager/Program Specialist upon admission? If so indicate individual's name, address, agency affiliation, if any, and phone # below. If not, indicate who, if anyone will be performing that function for/with the resident.

ASSESSMENT OF RESIDENT'S NEEDS

___ ___ Check to see if an assessment of the resident's needs has been completed by a Care Coordinator/Case Manager/Program Specialist or other appropriate party. If no other assessment has been done, you will need to assess the resident's needs as the assisted living plan is developed**.** Place a copy of the assessment in the resident's record.

EXISTING ASSISTED LIVING/CARE PLAN

___ ___ Does/did the resident have an existing Care Plan upon admission? If so, answer the following questions and place a copy of the Plan in the resident's record. If not, go to the next section.

___ ___ Was the existing Care Plan evaluated at the time of admission to the Assisted Living Home to determine if the plan meets the Assisted Living Plan requirements of AS 47.33.230? If so, place a signed/dated copy in the resident's file.

___ __ Were additions/revisions to the existing Care Plan made as the result of this evaluation? If so, place a signed/dated revised Assisted Living/Care Plan in the resident's file.

NEW ASSISTED LIVING/CARE PLAN

___ ___ For residents who did not have an existing Care Plan at the time of admission, has such a Plan been established according to the requirements of AS 47.33.230? (Sample form attached) Place a copy of the Assisted Living Care Plan in the resident's file.

___ ___ Did the resident participate in the preparation of the plan? Who else participated? (Indicate name, address, phone number, and affiliation, if any, below.)

HEALTH-RELATED SERVICES

___ ___ Are health-related services (as described in AS 47.33.020) to be provided or arranged for the resident as part of the Assisted Living Plan? If the answer is yes, answer the next two questions. If the answer is no, go to the next section.

___ ___ Has the health-related services portion of the Plan been reviewed by a registered nurse, as required by statute? If so, indicate the nurse's name, affiliation, and the date of review, below.

___ ___ Is a physician's statement about the resident included in the Plan, as required by statute? If so, indicate the physician's name, affiliation, and the date of statement, below.

EVALUATION OF ASSISTED LIVING/CARE PLAN

___ ___ Establish a date for evaluation of the resident's Assisted Living Care Plan. Under AS 47.33.240, an Assisted Living Plan must be evaluated at 3-month intervals if the Home is providing or arranging for health-related services to the resident. If health-related services are not being provided or arranged for, the Plan must be evaluated at least once a year.

CARE COORDINATOR/CASE MANAGER/PROGRAM SPECIALIST _____

ADDRESS, _____

AGENCY AFFILIATION, (if any) _____ TELEPHONE # _____

INDIVIDUAL WHO WILL BE CONDUCTING THE ASSESSMENT _____

ASSISTED LIVING HOME REPRESENTATIVE _____

Other Participants In Assisted Living Plan
(name, address, phone number, and affiliation, if any)

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